LOS ANGELES COUNTY COMMISSION ON HIV

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PLANNING, PRIORITIES & ALLOCATIONS (PP&A) COMMITTEE MEETING MINUTES

May 19, 2015

PP&A MEMBERS PRESENT	PP&A MEMBERS ABSENT	PUBLIC	COMM STAFF/CONSULTANTS
Al Ballesteros, MBA, *Co-Chair*	Rev. Alejandro Escoto, MA *(Alt. to Rivera)*	Melissa Fisk	Carolyn Echols-Watson, MPA
Brad Land, *Co-Chair*	AJ King, MPH	Anthony Mills, MD	Jane Nachazel
Michelle Enfield	Marc McMillin *(full to Soza)*	Juan Preciado	Yeghishe Nazinyan, MS, MD
Abad Lopez		Sabel Samone-Loreca	
Miguel Martinez, MPH, MSW		Scott Singer	
Juan Rivera		Terry Smith, MPA	**DHSP STAFF**
Ricky Rosales			Michael Green, MHSA, PhD
Patricio Soza			Mario Pérez, MPH
LaShonda Spencer, MD			Dave Young
Carlos Vega-Matos, MPA			

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1) **Agenda**: Planning, Priorities & Allocations (PP&A) Committee Meeting Agenda, *5/19/2015*
2) **Minutes**: Planning, Priorities & Allocations (PP&A) Committee Meeting Minutes, *4/21/2015*
3) **Table**: County of Los Angeles - Department of Public Health, Division of HIV and STD Programs, Summary Report, Ryan White Part A, Single Allocation Model (SAM) Care - Part B, and MAI Year 24 Expenditures by Service Category as of November 30, 2014, *2/28/2015*
4) **Table**: County of Los Angeles - Department of Public Health, Division of HIV and STD Programs, Summary Report, Centers for Disease Control and Prevention (CDC), Calendar Year 2014 CDC HIV Prevention (January 2014 - December 2014), 5/19/2015
5) **Table**: County of Los Angeles - Department of Public Health, Division of HIV and STD Programs, Summary Report, Net County Cost, Net County Cost Fiscal Year 2014-15 (July 2014 - June 2015), *5/19/2015*
6) **PowerPoint**: Ryan White Part A Minority AIDS Initiative (MAI) Overview, *5/19/2015*
7) **Report**: County of Los Angeles, HIV Care and Treatment Service Utilization, 2013 Year End Report (Draft), *May 2015*

1. **CALL TO ORDER**: Mr. Land called the meeting to order at 1:15 pm.

2. **APPROVAL OF AGENDA**:
   MOTION #1: Approve the Agenda Order **(*Passed by Consensus*)**.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION #2: Approve the 4/21/2015 Planning, Priorities and Allocations (PP&A) Committee meeting minutes, as presented **(*Passed by Consensus*)**.

4. **PUBLIC COMMENT *(Non-Agendized or Follow-Up)***: There were no comments.

5. **COMMITTEE COMMENT *(Non-Agendized or Follow-Up)***: There were no comments.

6. **CO-CHAIRS' REPORT**:

A. Comprehensive HIV Plan (CHP) Task Force Update:

- Mr. Land said the Task Force received more details at the last Executive meeting on soliciting a consultant to help develop the CHP revision due in 2016. The Task Force is reviewing guidelines on the cycle of assessment, planning, monitoring and evaluation. It will identify data points while the consultant will help update and incorporate data.
- The Task Force will also develop items for the as yet unscheduled Annual Report to the Board.

B. **Work Plan Update**: Mr. Land noted a meeting earlier that day which, in particular, addressed prevention. Questions were being framed. Sophia Rumanes, MPH will then assist in a review of each modality to identify information needed to make decisions. Mr. Ballesteros added PP&A's review of the Priority-and-Allocation-(P-and-A) Setting PowerPoint was helpful.

7. CO-CHAIR OPEN NOMINATIONS:

➲ Messrs. Ballesteros and Land were nominated. Nominations close and elections will be held at the next meeting.

8. FY 2014 FINANCIAL REPORT: Attendees stated their conflicts of interest.

- Mr. Young reviewed preliminary final Ryan White (RW) YR 24 data. The Summaries utilize HRSA service category definitions.
- The Part A grant term for funding of $36,602,272 ended 2/28/2015 with anticipated expenditures of $35,863,758 and under-spending of $828,514. Late invoices and cost report results will result in some adjustments expected to be minimal.
- Cost report analysis can identify expenditures either under-reported or over-reported. Some charges may be disallowed, e.g., if an agency was out of compliance with an audit requirement or should have billed a service to another funder
- The Part B (SAM Care) grant term ended 3/31/2015 for funding of $7,831,209 with anticipated expenditures of $6,962,146 and under-spending of $869,063. The majority of invoices have been submitted and cost reports were being reviewed.
- The Part A grant was maximized at this point in YR 23 review, but Part B reflected under-spending.
- The Minority AIDS Initiative (MAI) grant of $3,264,249 had expected costs of $725,761 and under-spending of $2,538,488. DHSP only charged costs to MAI from March through June 2014. Instead, expenditures were shifted to Parts A and B to help maximize them since MAI funds can be rolled over, but Parts A and B either cannot or incur penalties for doing so.
- Rolled-over funds will augment next year's allocation. A new MAI Plan was being developed to address those allocations.
- Mr. Young said DHSP funds over $4.6 million in Residential Services under Net County Cost (NCC) which has been used in the past to help maximize Parts A and/or B. DHSP recommended using that strategy to maximize YR 24 by shifting $828,000 in NCC Residential Services to Part A Housing Services and $869,000 in NCC Residential Services to Part B housing Services.
- Mr. Young confirmed the Commission does not allocate NCC funds, but can offer funding recommendations. He must also maximize the $17, 848,000 in NCC funds by its 6/30/2015 end of term and anticipated sufficient expenditures to do so.
- Mr. Vega-Matos added the Commission and DHSP have maintained an historical understanding and commitment to jointly support delivery of a range of HIV prevention, care and treatment services. It is especially important now to view the entire system through the lens of healthcare reform, migration, remaining RW services and increased savings from these changes.
- Dr. Green reported, previous to 2006, HRSA allowed jurisdictions to declare their NCC contribution as their Maintenance of Effort (MOE) which is required by RW legislation. In 2006, HRSA said jurisdictions could recalculate their MOE, but could only capture costs directly attributable to HRSA-approved service categories including those of health departments.
- DHSP, then the Office of AIDS Programs and Policy, did not want the County to reduce NCC to only costs of HRSA approved services. Instead, DHSP identifies eligible expenditures by County health departments, expenditures in data supplied by the Cities of Long Beach and Pasadena health jurisdictions and by the Cities of Los Angeles and West Hollywood to combine with eligible NCC expenditures and maintain the $17, 848,000 in MOE. That allows some NCC to be used for prevention.
- Most NCC prevention expenditures do not qualify for RW-eligible MOE expenditure calculations, e.g., most HIV testing is ineligible except that for Prevention for Positives. Other NCC funds are used for such services which include Medical Case Management, provided by a nurse in the Jail inpatient, or Mental Health Psychotherapy, a prior pilot project for the HIV-
- DHSP uses the NCC "Transfer in of costs from various grants" line item to fund administrative costs that exceed grant caps.
- Mr. Smith noted considerable community confusion over the definitions of NCC and MOE, what costs contribute to MOE and the fact that MOE has not declined. He suggested a DHSP report on the subject.
- The CDC HIV Prevention grant for January through December 2014 was $15,779,429 with expenditures of $15,437,503 and under-spending of $341,926. CDC under-spent funds may be rolled over and DHSP has submitted a request to do so.

➲ PP&A will advise Mr. Young if it needs more information on the funded modalities of CDC service categories.

➲ DHSP will identify for PP&A which NCC expenditures are also billable to RW or the CDC.

➲ DHSP will present to PP&A on NCC, MOE, the difference between them and NCC costs that contribute to MOE. After PP&A reviews the DHSP presentation, DHSP will incorporate any pertinent recommendations and present to the Commission.

Motion 3: (*Ballesteros/Land*): Recommend allocation of approximately $828,000 from Net County Cost Residential Services to YR 24 Ryan White Part A Housing Services and approximately $869,000 from Net County Cost Residential Services to YR 24 Ryan White Part B Housing Services to maximize the Ryan White Part A and B awards **(*Passed: Ayes,*** Ballesteros, Enfield, Land, Lopez, Martinez, Rivera, Soza, Spencer, Vega-Matos; ***Opposed,*** None; ***Abstention,*** None**)**.

9. **FY 2014 ALLOCATIONS**: There was no additional discussion.

10. **FY 2015 ALLOCATIONS**: This item was postponed.

11. **MINORITY AIDS INITIATIVE (MAI) OVERVIEW**:
    - Dr. Green provided a PowerPoint overview of MAI to help inform development of an allocation plan for FY 2014 savings, plan revision after FY 2015 award receipt and consideration of how to address unmet need and the unaware going forward.
    - The Congressional Black Caucus (CBC) launched the MAI Initiative in 1999 to address HIV among people of color and identified populations for jurisdiction focus. Awards were based on population proportions within jurisdictions and required contracted CBC agencies to increase service dollars and build capacity among minority run and focused agencies.
    - The 2006 RW HIV/AIDS Treatment Modernization Act incorporated MAI as a separate, competitive program in FYs 2007-2009. Contract requirements changed to mirror other RW contracts which eliminated the minority agency focus.
    - The 2009 RW HIV/AIDS Treatment Extension Act ended the need for MAI programming to look different from that of Part A.
    - The foci remain on unmet need and on addressing disparities in access to care and health outcomes among minority populations disproportionately impacted by HIV/AIDS. An additional focus since 2010 has been on the unaware population reflected by the Early Identification of Individuals with HIV/AIDS section of the RW grant application.
    - The current DHSP application overall estimate for unmet need based on surveillance is 12,000. The undiagnosed estimate in the EIIHA application section is 9,000 based on a CDC formula. Mr. Pérez added Amy Wohl, MPH, PhD estimated approximately 22,000 people were either undiagnosed or diagnosed and not in care (unmet need). Approximately 23% of PLWH are African-American and 40% are Latino. Adding smaller populations such as Asian/Pacific Islander, American Indian and Alaskan Native brings the minority total closer to 75%. Caucasians typically were 30%, but that was declining.
    - The overarching goal to improve health outcomes includes preventing transmission and slowing disease progression with earlier entry into care, assuring access to treatments consistent with established standards of care and retention support.
    - HRSA requires MAI and Part A funds to address core medical and support service needs among disproportionately impacted communities. Combined MAI and Part A service expenditures must meet the 75% core medical requirement unless HRSA grants a waiver. Planning councils may now choose a separate MAI P-and-A process or combine it with Parts A/B P-and-A.
    - Services must comply with HRSA National Monitoring Standards. HRSA requires an annual plan, utilization and outcomes via its Electronic Handbook (EHB) online portal. Utilization and outcomes must be reported by service category, race/ethnicity and include data on Women, Infants, Children and Youth (WICY) served. One HRSA outcome measure is required.
    - MAI reporting requires data for each targeted race/ethnicity for each allocated service category. DHSP must identify in advance specific objectives and outcomes including the proportion of minority populations that will be served by contracted dollars. DHSP must manually populate data into the EHB used to manage the RW grant. The portal closes in between submission periods and cannot be printed or viewed. It will open for the next due date at the end of July 2015.
    - Required data includes: allocation and expenditures for each racial/ethnicity group and service category; planned number of clients and service units, including WICY; and planned and final outcomes and numbers/percent achieved from program reports and Casewatch linked to the contracts. Reporting becomes problematic when contracts are moved from MAI to Part A funding because Casewatch is not sophisticated enough to separate funding data by time under each grant.
    - The amount of detail required for each service category makes managing the grant cumbersome. The Commission has historically addressed that issue by funding two or three service categories at a time with funds proportioned among them.
    - MAI was maximized for the last two years. Funds were rolled over from 2010 and 2011 and invested in the expansion of Oral Health services and implementation of Medical Care Coordination (MCC).
    - Planning council responsibilities are consistent with Part A and can be conducted with it. They include: conducting a needs assessment for the jurisdiction, including unmet need, with demographic data used for allocations; P-and-A; and developing an MAI-specific plan consistent with the Comprehensive HIV Plan (CHP) that includes outcome expectations and measures.
    - Dr. Green noted YR 25 began 3/1/2015. DHSP had not yet received the award but, with the roll-over, total funding was expected to be approximately $5.5 million. Awards are based on epidemiology and the amount of available MAI funding.

- MAI service allocations for 2013, 2014 and 2015 included Oral Health each year at 30%, 40% and 40% respectively. MCC was also funded all three years at 45%, 40% and 40% respectively. Linkage to Care (early intervention) was funded in 2013 at 25%, but replaced in 2014 and 2015 with Transitional Case Management at 25% each year.
- MAI funds are always spent last because it is the only part of the RW Part A grant that can be rolled over without penalty with approval of HRSA HAB and the Project Officer. Any carryover must be spent in the year to which it was carried over.
- Part A supplemental funding is based on application quality and its demonstration of need. It cannot be rolled over. Part A formula funding, like MAI, is based on epidemiology. A Part A formula Unobligated Balance (UOB) of >5% subjects the next year's award to reduction by the UOB less any approved carryover and the jurisdiction will be ineligible for the next year's supplemental award. A Part A formula UOB equal to or <5% carries no penalty, but the future year's award may be offset.
- Any MAI carryover request has to be submitted after the County's final financial report. HRSA reviews requests as received. The earliest possible submission will facilitate early award notification which allows the jurisdiction to better utilize funds.
- The planning council needs to approve the MAI carryover plan and allocations in June to move the request quickly. In July, the grantee/administrative agency submits the request to HRSA, the HRSA Project Officer determines whether to approve the request, any approved funds are included for the next year and the grantee/administrative agency submits the annual MAI plan including carryover. HRSA then reviews/approves the plan and the grantee/administrative agency tracks spending, utilization and outcomes. The grantee/administrative agency submits the final MAI expenditures and report in January.
- Dr. Mills asked if HRSA could reject the plan. Dr. Green said it could and then redistribute funds, but it was very unlikely.
- An allocation plan was needed in June to carry forward FY 2014 savings to the FY 2015 (3/1/2015 - 2/28/2016) grant year.
- Mr. Rivera felt continued fund roll over suggested not maximizing funds in the intended highly impacted minority areas. He understood funds were being shifted across funding streams and asked if funds would serve those areas there.
- Mr. Vega-Matos reiterated that funds were not rolled over for the past two years. Some accounts were being shifted from MAI to other funds to maximize the latter. The landscape has also changed so some MAI services now have other payer sources such as Oral Health. As payer of last resort, the MAI plan must take those other payer sources into account as well as services funded by the $10-12 million in RW Parts C and D funds. Many jurisdictions were struggling with this issue.
- Mr. Pérez said MAI is a microcosm for a larger issue. A conversation on MAI's $2.5 million in funds is important, but should not eclipse a longer conversation on $48 million in combined Parts A and B and overall system. All 100% of MAI resources serves people of color but, given the County's epidemiology, DHSP spends 80% of all resources to serve people of color.
- ACA is effecting its intended purpose and dramatically shifting who pays for HIV medical care, the largest RW service over the past 20 years. That is good in freeing funds for needed ancillary services, but also shrinks need for some Part A services. It is useless for DHSP to contract services if providers can only invoice some 80% of contracts leaving millions on the table.
- There are multiple reasons a provider may not spend down a contract. Patients may now be eligible for services from another payer sources, e.g., Medi-Cal. Providers have difficulty hiring certain staff, e.g., the scarcity of available mental health clinicians has reduced expenditures by some $500,000 per year. DHSP worked diligently to expand Oral Health with planning and resources resulting in many new dental chairs, but some contractors have spent a fraction of their contracts.
- MCC is designed to ensure those most at risk of dropping out of care have an RN, social worker and case aid to help address issues, but the impact was less than desired. Should staffing be increased? That is an issue for PP&A to consider.
- DHSP was implementing new linkage, retention and care programs. DHSP has also tried multiple case management programs for inmates being released from County Jail to link them to their prior or a more appropriate medical home, but results have been mixed due to the complexity of life situations. These services provide care and treatment for PLWH, but do not address upstream issues such as income inequality, housing instability, educational attainment and employment.
- Providers have a short period of time to maximize resources from Parts A, B, C, D, F and Medi-Cal and Covered California.
- Mr. Ballesteros asked about a major outreach program to bring people into care. Mr. Pérez posited a $5 million Linkage to Care (LTC) program. An RFP would need to be developed to bring in community partners, but surveillance data would be needed first. Assume 9,800 PLWH in the system with no evidence of a Viral Load in the last six months and an estimated 1,000 who have left the County. DHSP cannot, however, share surveillance data with Community-Based Organization (CBOs). DHSP has explored every legal avenue and it is not allowable so CBOs would need to use other identification means.
- CBOs would also need to hire, train, retain and bill for 50 to 70 staff in two years in a field with high turnover.
- Mr. Vega-Matos added there were also many CDC directly funded LTC programs. They have historically done a good job in connecting people to care, but were now asking DHSP for help in locating and reaching the hardest to reach.
- Mr. Smith appreciated the contextual information, but the purpose of MAI was to improve health outcomes for people of color and improvement was minimal, e.g., one in three African-American MSM are infected, a number fairly static since 2006 as are indicators such as retention in care and viral suppression. The system is excellent once PLWH are in it, but many are lost to care. He suggested a work group focusing on how to craft MAI to make a real difference among people of color.

- Mr. Vega-Matos noted Dr. Wohl and Sophia Rumanes, MPH presented at a recent Commission meeting on how the Department of Public Health can assist in using surveillance records to reach some out of care PLWH by Incorporating LTC workers in medical homes. A work group is finalizing program elements. Initially, 12 staff with community-based health experience will be retrained for the program. Staff have not necessarily been fully oriented on use of surveillance data or have experience linking PLWH to care who have left care and have multiple psychosocial issues. Roll out is expected by July.
- DHSP will be working with CBOs including medical clinics, dental clinics and other system entry points to introduce the LTC workers. The first three months will provide information on working out any issues prior to expansion. Initial new costs will be low due to use of DHSP staff. Expansion will require allocations to Outreach.
- Ms. Fisk asked about Transitional Case Management (CM). Mr. Pérez replied DHSP offered an opportunity for agencies that historically provided Psychosocial CM to transition to Transitional CM when MCC absorbed the former. Some chose to evolve while others did not. Transitional CM is a complementary service to MCC.
- ➲ An MAI Work Group was formed to address the plan within the next few weeks. Members were: Mr. Ballesteros, Ms. Enfield, Dr. Mills, Mr. Smith, Dr. Spencer and Mr. Vega-Matos. Ms. Echols-Watson will coordinate.

12. SERVICE UTILIZATION REPORT (SUR) OVERVIEW:

- Dr. Green presented on the HIV Care and Treatment Service Utilization, 2013 Year End Report (Draft). DHSP develops a SUR annually. It is completed 18 to 24 months after the SUR year to allow time to collect and review data.
- The SUR's initial purpose was to provide data for the planning council's responsibility to assess whether service utilization was consistent with planning council RW funding allocations and intentions. It has also became helpful in informing P-and-A and community stakeholders often reference the data when writing grant applications or other kinds of reports.
- This will be the last SUR that includes only care and treatment. The next SUR will reflect the full continuum.
- The Appendix includes a cross-walk of service categories as allocated in 2013 and the HRSA categories that will be used in future. Commission allocation percentages were moved from the body of the SUR, where they caused some confusion, to the Appendix. The Commission did not allocate to some HRSA-eligible categories, e.g., Health Insurance Premiums.
- Epidemiological tables are also in the Appendix. Demographic characteristics data is reported on race/ethnicity, gender, age, transmission category and SPA. Separate tables compare demographic characteristics of all RWP clients to those receiving AOM, retention in care and viral suppression among all RWP clients by demographic characteristics, and demographic characteristic of all RWP clients by SPA. DHSP was transitioning from data by SPA to data by cluster map.
- The Continuum of HIV Care reflects HRSA-defined services with prevention on the left moving toward viral suppression and reduced transmission on the right. Services are aligned along the Continuum where their impact is greatest.
- Starting with the Client Summary, the SUR shifts from addressing all PLWH/A in the County to those who received a DHSP-funded service in 2013. Approximately 36% of diagnosed PLWH/A in 2013 received at least one such service in 2013.
- Each jurisdiction can determine the income/poverty level at which it will provide RW services. The County uses different levels for different Ryan White Program (RWP) services. As expected for the RWP population, 47.6% had no insurance; 45.3%, public; 6.2%, private; 0.5%, other; and 0.4%, unknown. 2013 was the second major transition year in California due to early ACA roll out. Consequently, many of the 18,123 clients in the RWP had not yet migrated to other medical care in 2013 while others received RWP medical services early in the year and then migrated to another payer source.
- A separate section reports on clients with special needs: homelessness, incarceration, mental health and substance abuse.
- For the first time, this SUR addresses actual client outcomes. Previously, it addressed utilization and expenditures, but not service effectiveness. DHSP initiated outcome data with two basic indicators: retention in care and viral suppression.
- Ms. Samone-Loreca noted male and female client data was similar, but the transgender client viral suppression rate was notably lower. Dr. Green replied outcome data cannot necessarily help identify disparities, but helps identify areas to question, e.g., by deeper review of Casewatch data to explore disparities. Future SURs will add more data points. The data will become more valuable once married with Los Angeles Countywide Coordinated HIV Needs Assessment (LACHNA) data.
- Data on key services accessed by type of insurance will change dramatically for SURs going forward due to ACA.
- DHSP's overarching HIV care and treatment goals are to increase access, retain PLWH in medical care, ensure PLWH are receiving ART and achieve viral suppression. It is not possible at this point to identify a direct effect of a particular service on achieving goals. It may be possible to do multivariate analysis in future after more data points have been collected.
- This SUR also provides a comparison of services accessed by PLWH new to the RWP and those who have returned to it after having dropped out of care. Services accessed reflect a distinct difference in needs between the two populations.
- Chapter 4 begins review of individual service categories starting with core medical services. Each service category review includes the HRSA definition, the Commission definition/guidance and what DHSP funded in 2013. Tables provide information on expenditures and funding sources for the service, utilization by numbers of encounters and client

demographic characteristics. Care access and health outcomes are graphed for pertinent services and, for Ambulatory Outpatient Medical (AOM), a graph reflects the distribution of clients by frequency of medical visits.

- Dr. Green noted the highest AOM utilization was in 2008 with 16,000 to 17,000 clients accessing the service. By 2013, only 9,367 clients were accessing AOM. The number will continue to decrease through 2014 and 2015. The 79.8% viral suppression rate for RWP AOM clients in 2013 did not yet meet DHSP's goal, but was better than the national average.
- The SUR was in internal review prior to finalization. It will be posted on DHSP's website once finalized.
- Request: DHSP will add to SUR a chart identifying what proportion of various populations access various services to include: top five services accessed by percentage of males, females, transgender people; and African-Americans, Latinos and other populations in the RW system.
- Request: DHSP will break out Therapeutic Monitoring Program information in the SUR's AOM section.
- Other SUR requests can be emailed to Dawn McClendon and copied to Messrs. Ballesteros and Land. Requests should be emailed within the next week for DHSP review. Ms. McClendon will compile requests and forward them to Dr. Green.

13. NEXT STEPS:

A. Task/Assignment Recap: Three was no additional discussion.

B. **Upcoming Meeting Agenda**:

- The Work Group will meet prior to the 6/16/2015 PP&A meeting, 12:00 noon to 1:00 pm, to prepare for LACHNA review and service rankings at PP&A. Service rankings must be completed in June to meet DHSP application timelines.
- Reserve 6/23/2015, 1:00 to 4:00 pm, for supplemental PP&A meeting to complete service rankings, if needed.

14. ANNOUNCEMENTS: Ms. Enfield encouraged everyone to register for the 6/30/2015 Trans Summit.

15. ADJOURNMENT: The meeting adjourned at 4:15 pm.